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[redacted]

January 7, 2011

Arizona Department of Health Services
Division of Public Health Services
150 North 18th Avenue
Phoenix, Arizona 85007

RE: Public comments to DHS draft regulations concerning Proposition 203 (Medical Marijuana)

Dear Sir/Madam:

Please find attached the Chandler Police Department's comments to DHS draft regulations concerning Proposition 203 –Medical Marijuana. As a general matter, the draft regulations do a very good job outlining the application and licensing of patients, caregivers and dispensaries. The ability to regulate who may obtain, provide and dispense medical marijuana is of great concern to law enforcement. The draft regulations adequately address the ability of law enforcement to access the DHS licensing database. This will be key to determining a person's lawful right to possess and distribute medical marijuana

With that said, there are many other law enforcement concerns that are not addressed. The two largest are the lack of meaningful regulation regarding the transportation of medical marijuana by dispensaries and caregivers, and the possession, storage, safekeeping and processing of marijuana-infused food products by food establishments. These two areas need further regulation to protect the public and those involved in the medical marijuana industry.

The attached comments are arranged according to regulatory section. I hope they are useful to you in devising a workable system that will further the intent of the proposition while protecting the public. If the Chandler Police Department can be of further assistance, please do not hesitate to call

Respectfully,

Thomas Zaworski
Assistant Chandler City Attorney
Police Legal Advisor Unit

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Chandler Police Department Comments on DHS Draft Regulations for Medical Marijuana

R9-17-101 – Definitions

(18) – Public place – The definition does not specifically include substance abuse treatment/counseling centers.

R9-17-106 – Adding a Debilitating Medical Condition

This section addresses the method for adding debilitating medical conditions, but there is no method for removing a debilitating medical condition that was added under DHS regulations (as opposed to statute). For example, there may be additional research in particular areas of medicine that disputes prior studies pertaining to the benefits of medical marijuana for particular debilitating illnesses.

R9-17-202 – Applying for Registry ID Card for Qualifying patient or Designated Caregiver

(A)This section essentially states that only qualifying patients under 18 need to have a designated caregiver It seems the regulations should require a designated caregiver for a patient who is under guardianship or medical power of attorney.

(F)(1) In addition to the list of required information, the patient should be required to disclose whether he/she is under any court order pertaining to guardianship, mental health order, or whether anyone else holds medical power of attorney, and if so, the case number, and the name of the guardian, case manager or person holding power of attorney Additionally, said guardian, case worker, court or person holding power of attorney is aware of the patient request for medical marijuana and consents to the request

(F)(5) In addition to the requirements of the physician's certification, a statement that the physician is/is not aware of any court order pertaining to guardianship, mental health order, or whether anyone else holds medical power of attorney, and if so, the case number, and/or the name of the guardian, case manager or person holding power of attorney. Additionally, said physician is/is not aware of any mental or emotional disability that would be negatively impacted by the ingestion of medical marijuana. Finally, the physician should be required to state a recommended ingestion method, e.g., smoking, eating, drinking, pill form, etc.

(G) This section lists requirements for patients under 18. It should also include requirements for patients who are subject to any court order pertaining to guardianship, medical power of attorney, mental health order. For example, instead of having the requirements pertain to a parent, have them apply to the person or agent of the entity that controls medical decisions.

The regulations should also include an affirmative, ongoing duty that the patient or caregiver inform the Department of a conviction for any excludable felony within 10 days of the conviction This requirement should apply as well to dispensary agents, officers and board members.

Finally, ARS 36-2801(5) allows caregivers to assist up to five patients and either grow up to twelve plants per patient, or possess up to 2.5 ounces of marijuana per patient. Assuming the caregiver is also a licensed patient, the caregiver could legally grow up to 72 plants or possess up to 15 ounces of marijuana (almost a pound). In order to prevent the unregulated operation of large-scale grow sites or possession of

large quantities of marijuana by an "association" of multiple caregivers living at or associated with one location, the regulations should prohibit more than 72 plants or 15 ounces of marijuana at any one location. This would go a long way in preventing "de facto" illegal cultivation sites.

R9-17-302-R9-17-305 – Applying for, changing, renewing Dispensary/cultivation site registration certificate

The regulations require the applicants to submit a signed statement that the facilities are incompliance with local zoning laws The regulations should require that the applicant submit a letter from the local zoning body indicating the facilities are in compliance Additionally, the regulations should require applicant to inform the Department within 10 days of being notified by the local zoning body that the dispensary/cultivation site is out of compliance with local zoning laws.

R9-17-306 – Inspections

(D) This section precludes the Department from accepting anonymous-source allegations of a dispensary's noncompliance with Title 36, chapter 28.1 requirements. This section seems to unnecessarily hamstring the Department's ability to enforce its own regulations Even criminal constitutional law allows police to use anonymous sources of information, if they comply with certain prerequisites. For example, police can use anonymous source information if reliability is shown, either by the source reliably predicting future behavior, or through independent corroboration of the anonymous information. This regulation specifically cuts off this possibility.

(F) This section seems to require the Department to give notice and a chance to rectify a statutory or regulatory violation. It does not allow for any possibility of immediate cease/desist. For example, what if the Department discovers blatant felony violations? Is the dispensary still given 20 days to submit a corrective notice? This seems to be an absurd outcome.

R9-17-310 – Medical Director

This section requires the medical director to be available during hours of operation, but it fails to set forth any time frame within which the medical director must respond to communications, or for any repercussions if he/she is not available as required (e g , loss of ability to act as medical director). Additionally, it fails to require coverage for the medical director when he/she is unavailable (e g , on vacation, sick, etc.).

R9-17-311 – Dispensing Medical Marijuana

This section places responsibilities on the dispensary agent. There is no requirement, however, that the patient/caregiver avow that the amount dispensed will not place the caregiver/patient in possession of more than 2.5 ounces of medical marijuana If this is not required, then patients/caregivers could "hoard" prior amounts. This would make it very difficult for law enforcement to prove a patient/caregiver is in violation of state law/regulation.

R9-17-313 – Inventory Control System

(B)(3) – This section pertains to cultivation. While it includes certain tracking, it fails to require the cultivation site to provide to the Department a record of utility usage. Such records can be useful in

determining whether there has been an increase in cultivation, and consequently whether cultivation records accurately reflect an increase in yield.

R9-17-313(B)(5) and (6), and R9-17-314

While these sections provide for regulation of the dispensary providing marijuana to and receiving infused food products from a food establishment, there is no regulation of the food establishment itself or of the company or persons receiving the marijuana or preparing the product. (As an aside, R9-17-307(C) does not specifically allow for dispensaries to provide marijuana to food establishments for infusion purposes, although R9-17-315(B) allows for dispensaries to transport marijuana to food establishments). There is also no requirement that the food product list the quantity and type of marijuana or the amount of active ingredient in the food product. Finally, there is no requirement that the food establishment obtain its marijuana from a dispensary within the state or that the dispensaries obtain their food products from food establishments within the state.

R9-17-315 – Security

General concerns - This section places certain security requirements on dispensaries. It does not, however, place any requirements on the dispensary for the packaging, labeling, or securing during transportation of medical marijuana to/from other dispensaries, qualifying patients or caregivers, or food infusion establishments. Indeed, there are no restrictions or limits for the amount of marijuana that can be transported at any given time.

Law enforcement has real concerns involving transportation of medical marijuana. Those concerns involve 1) the safety of the dispensary agent, the patient and the caregiver who may be targeted for theft/robbery while transporting, delivering or receiving medical marijuana, 2) the ability to distinguish medical marijuana from potentially illegal marijuana that may be transported at the same time. It seems prudent to require that all medical marijuana be labeled so that it lists such things as the source, type, dispensary, transporting agent, intended recipient, quantity received by each recipient, the date, time and location of delivery, and the name, title, identification and signature of the actual recipient. The marijuana should be transported only in a vehicle that does not indicate it is transporting medical marijuana or affiliated with a dispensary. The marijuana itself should be transported in some secured manner, such as a secured, locked container accessible only by an authorized dispensary agent. This will help reduce and/or deter incidents of theft, robbery and assault.

Except for limited exceptions, the regulations do not address security or regulation of food establishments that receive and infuse medical marijuana. This is a glaring oversight and is possibly the largest hole in the regulatory scheme. If dispensaries will be transporting medical marijuana to such food establishments, the regulations should place requirements on the food establishments and their workers similar to those placed on dispensaries and dispensary agents. Those should include:

1. licensing requirements of the establishment, and proof that the establishment is in compliance with all local, state and federal regulations pertaining to food processing and handling;
2. Background checks and licensing of its board members and employees;
3. facility security and monitoring requirements similar to those of dispensaries;
4. limits on infusion facility locations
5. inventory control, oversight and management;
6. accounting standards for the marijuana;

7. limiting access to areas where medical marijuana or infused food products are located;
8. If other than infused food production occurs on site, physical facility separation from marijuana storage and infusion

(C)(2) – Policies and procedures – This section should require policies and procedures for ensuring that video systems are tested on a regular basis, and that system failures are rectified promptly, preferably within a specified time frame, or that the facility be shuttered until the security system becomes fully functional.
(C)(1)(c) – This section addresses where video cameras are to be located. There is no requirement that packaging areas be monitored. This would be useful in maintaining inventory control and deterring agent theft of the marijuana.

R9-17-317 – Cleaning and sanitation
(B)(4) requires reports to the medical director of any health condition of an agent that may adversely affect the safety or quality of the medical marijuana. There is no requirement that the medical director notify the Department either of the medical condition or the agent's recovery. Such information would be necessary if the Department wished to suspend the agent's license while he/she had such a medical condition.

R9-319(c)(1) – This section allows for dispensary license revocation under certain circumstances. It should also include a provision for revocation if the department is notified that the dispensary has fallen out of compliance with local zoning laws.

City of Phoenix
PLANNING AND DEVELOPMENT SERVICES

January 7, 2011

Will Humble, Director
Arizona Department of Health Services
150 North 18th Avenue
Phoenix, Arizona 85007

Re: Preliminary Comments on December 17, 2010 Proposed Rules R9-17-101 *et seq.*, Regarding Medical Marijuana

Dear Director Humble:

Thank you for the opportunity to comment on the above draft rules. The following are the City of Phoenix's preliminary comments. Please note that these comments are those of City staff members and not those of the Mayor or Council. We look forward to working with you on these rules as they evolve.

Overall, the proposed rules are very thorough. There are just a few areas where we would suggest some clarification.

R9-17-101. Definitions.

"Dispensary" is defined the same way that it is in the statute. However, the rules seem to anticipate "cultivation sites" which may be separate from the more retail "dispensary". Even though the statute mixes the two concepts (retail sales and cultivation in its definition), we would suggest adding a definition of "cultivation sites" to make it clear which type of use is being regulated in different sections of the rules.

R9-17-316. Edible Food Products

We think that there may be a number of products that may use marijuana as an ingredient, among them are lotions, balms, and baked goods or other types of food. In order to cover all types of products, we suggest renaming the section something like "Infused Products."

Because the creation of "infused" products could have some negative secondary land use effects, such as gases or vapors emitting from the production facility, the City of Phoenix would require these uses to be in industrially zoned areas. They would be treated differently from a bakery, say, within a grocery store, that could be located in a C-2, Intermediate Commercial zoning district. Because of these potentially negative effects, we would suggest that the rules do not permit marijuana-infused food to be produced side-by-side with other food products.

R9-17-313 Inventory Control System

Subparagraph B 5 describes inventory control for providing medical marijuana to a "food establishment." Again, the City believes that this term should be changed to a more general one, such as "infused product."

Subparagraph B 5 b ii suggests that a person who receives medical marijuana at an infused product facility should be a "designated agent." A "designated agent" is not defined in section 101, but "dispensary agent" is defined. It means the same as "non-profit medical marijuana dispensary agent" as defined in A.R.S. § 36-2801. It is not clear whether the proposed rules would regulate a food or other product with infused marijuana in the same manner as a dispensary. The City believes that the infused product facility should be regulated in the same manner as a cultivation site or a retail dispensary, as discussed above, because of the presence of medical marijuana.

R9-17-302 Applying for a Dispensary Registration Certificate

Subparagraph B 5 requires an applicant to provide a copy of the certificate of occupancy or other documentation issued by the local jurisdiction to the applicant authorizing occupancy of the building as a dispensary. Certificates of occupancy are not issued until the structure and all of its tenant improvements (and possibly, off site improvements) have been completed. These can be costly for an applicant, and would most likely not be done at the time an application is made. The City suggests that the rules require that a cash bond be posted with the City to ensure that needed physical improvements are made prior to issuance of a Certificate of Occupancy.

Subparagraph B 6 requires a sworn statement by the applicant certifying that the dispensary is in compliance with local zoning restrictions. The City suggests that the rule instead require a statement signed by the local zoning official (in Phoenix, the Planning and Development Department director) that a given site meets zoning restrictions. Further, in Phoenix (and some other cities), there will be a timing problem, as the newly adopted zoning ordinance requires a dispensary to find property in the

proper zoning district and to *then* secure a use permit. The City suggests a state investigative process that would involve a two step procedure: The first step would involve the DHS qualifying an entity for a dispensary license. The second step would require the entity to work with the local jurisdiction to find an appropriate location (and in Phoenix, secure a use permit). Upon finding that location and securing the use permit, the entity would return to DHS to finalize the steps necessary to secure the state license.

R9-17-304 Applying for a Change in Location for A Dispensary or a Dispensary's Cultivation Site

Subparagraph A 2 - see above comment in R9-17-302 B5.
Subparagraph A3 - see above comment in R9-17-302 B6.

R9-17-307 Administration

Subparagraph C requires that a "dispensary" must cultivate at least 70% of the medical marijuana the dispensary provides to qualifying patients or designated caregivers.

First, the use of the term "dispensary" under the statute includes both a retail outlet and a cultivation site. As noted above, the City suggests a clarification in the definition section to separate a retail dispensary from a cultivation site.

Second, the rule seems to suggest that each retail dispensary must also cultivate the marijuana that it sells. If the goal of this rule is to ensure that marijuana sold in Arizona is grown here, the City suggests that the rule be clarified to permit the opportunity for a separate retail dispensary to acquire its marijuana from an Arizona cultivation site which it does not own. This might encourage cultivation in large quantities, which would be easier for cities to monitor and regulate.

Third, as a matter of arithmetic, it is impossible to calculate 70% (or any other percentage) unless some definite time period is prescribed for purposes of the calculation. Because it would be unwieldy to specify a time period that is too short (*e.g.*, daily) we suggest that any such regulation should specify that the calculation should be made on an aggregate, annual basis.

We look forward to working with you on the rules as they are formulated. Please call me at (602) 495-5412 if you have any questions about our comments.

Sincerely,

FOR. DEBRA STARK

Debra W. Stark
Planning and Development Director

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c: Larry Tom
Margaret Wilson

ARIZONA CHAMBER
of Commerce and Industry
Uniting Business Advancing Arizona

[redacted]

January 7, 2011

Will Humble, Director
Arizona Department of Health Services
150 N 18th Avenue
Phoenix, AZ 85007

Re: Rules and Regulations of Medical Marijuana in the State of Arizona

Dear Director Humble:

Thank you for meeting with the Arizona Chamber of Commerce and Industry's (the "Arizona Chamber" or "Chamber") Workforce and Insurance Committee (the "Committee") to discuss Arizona's new Medical Marijuana Act (the "Act") and the Department of Health Services' (the "Department" or "DHS") proposed rules to implement the Act. We appreciate you taking the time to meet with the Committee, to discuss concerns, and to provide the opportunity for input from the Chamber on issues associated with the new law. The Committee members have cooperated to develop the comments we are submitting.

1. Introduction and General Principles

For more than 35 years the Arizona Chamber has served as the leading statewide advocate for the Arizona business community. Its members employ more than a quarter of a million Arizonans in all sectors of the economy, working for small, medium and large employers. The mission of the Arizona Chamber is as follows:

> The Arizona Chamber of Commerce and Industry is committed to advancing Arizona's competitive position in the global economy by advocating free-market policies that stimulate economic growth and prosperity for all Arizonans.

The Arizona Chamber has adopted five guiding principles:

1. Promoting a globally competitive tax climate.
2. Decrease the regulatory burden on business.
3. Sustain a strong workforce.

4. Maintain a strong infrastructure.

5. Support economic development and diversification.

An explanation of each of those guiding principles and additional information regarding the Chamber and its policy positions can be found on the Chamber's website at http://www.azchamber.com.

An overriding interest of the Chamber is to urge the adoption of regulations that maximize the security procedures for medical marijuana supplies, from cultivation through consumption, in order to minimize the potential that the Act could result in unauthorized users, including employees, obtaining supplies illegally

The business community strongly believes that security is a very important part of the regulations and oversight that the Department of Health Services should implement. Technology exists today to ensure that biometrics and security features are incorporated to prevent fraud and abuse regarding the use of medical marijuana. Employers are concerned with safety issues, especially regarding safety-sensitive positions. Arizona should develop the best standards for ensuring safety, security and preventing misuse. Arizona has the opportunity to do what, thus far, none of the other states with medicinal marijuana laws has accomplished: establishing a safe, secure, efficient and virtually fraud-proof system for the cultivation, sale and use of medical marijuana. Arizona should be the leader in this area.

Please feel free to contact us with any questions. We appreciate your consideration of these suggestions

2. Definition of Terms

There is an important term that is undefined in the Act which should be clarified in the definition section of the rules. The term "monetary or licensing related benefit under federal law or regulation" is included in A.R.S. § 36-2813(B). As set forth below, we suggest that the definition of that term include, at a minimum, employers who receive federal funding and grants, obtain a federal license, and/or secure a federal contract of any kind.

In compliance with the federal Drug-Free Workplace Act of 1988, any firm with a single (or more) federal contract of more than $100,000 is subject to the Drug-Free Workplace Act. This would include any employee, full-time or temporary, who works on any activity under the grant or contract. Additionally, contractors or grantees performing work in federal facilities,

involved in federal procurement of utility services, issued other contracts or grants to educational organizations are included in these provisions covered by the Act.

Furthermore, the United States Department of Transportation (DOT) has drug policy regulations under its Drug and Alcohol Testing Regulation. 49 C.F.R. § 40.151(e). These regulations do not authorize "medical marijuana" allowed under a state law to be a valid medical explanation for a transportation employee's positive drug test result. DOT has declared the following transportation positions as safety-sensitive and therefore, unacceptable for these employees to use medical marijuana based, even if consumed in compliance with DHS regulations: pilots, school bus drivers, truck drivers, train engineers, subway operators, aircraft maintenance personnel, transit fire-armed security personnel, ship captains and pipeline emergency response personnel We suggest that employers of workers in safety-sensitive occupations also be included within the definition of recipients of "monetary or licensing related benefit under federal laws or regulations."

A number of federal agencies (including the Department of Defense, Department of Energy, Nuclear Regulatory Commission and National Aeronautics and Space Administration) have issued regulations that require federal contractors, grantees and licensees to maintain fitness-for-duty requirements or drug-free workplace programs. For example, licensees for the Nuclear Regulatory Commission ("NRC") are also held to similar regulations as DOT through the NRC Fitness-For-Duty program as defined in 10 C.F.R. Part 26. The NRC regulation addresses the concern of trustworthiness and reliability as related to use of medical marijuana and other hallucinogens. Its regulation is imperative to ensure individuals who are subject to Part 26 requirements are not impaired from using drugs when performing duties subject therein. As this prohibition has concurrence from the Departments of Justice and Health and Human Services, as well as the Office of National Drug Control Policy, we request personnel in these and similar positions also be included in the definition of "monetary or licensing related benefit under federal laws or regulations."

There are also situations in which employers may legitimately believe that they must maintain a drug testing or drug-free workplace policy in order to achieve the monetary benefit of avoiding citations and penalties under the federal Occupational Safety and Health Act ("OSHA"), which in Arizona is administered by the Arizona Division of Occupational Safety and Health ("ADOSH") of the Industrial Commission of Arizona. Under federal OSHA law, ADOSH must enforce standards at least as stringent as federal law and regulations, and must enforce the OSHA general duty clause, which is codified at A.R.S. § 23-403(A). That law obligates each employer to "furnish to each of his employees employment and a place of employment which are free from recognized hazards that are causing or are likely to cause death

or serious physical harm to his employees." There will be circumstances in which employers believe that they must enforce drug-free workplace policies to comply with OSHA, and compliance with OSHA is necessary to achieve the monetary benefit of avoiding citations and penalties under OSHA. Consequently, the definition of "monetary or licensing related benefit under federal law or regulations" should also include compliance with OSHA

Incorporating all of the above recommendations, the following is a definition of "monetary or licensing related benefit under federal law or regulations" that should be included in DHS's rules:

> *"Monetary or licensing related benefit under federal law or regulations" means any federal statute, regulation or provision of any federal grant, contract or other federal program, including but not limited to the Drug-Free Workplace Act of 1988, requirements of the Department of Transportation, Department of Defense, Department of Energy, Nuclear Regulatory Commission, National Aeronautics and Space Administration, or Occupational Safety and Health Administration, that causes an employer to adopt, implement or enforce any policy, practice or personnel action intended to maintain a drug-free workplace, including but not limited to drug testing, reassignment from safety-sensitive positions, or discipline or termination of an employee believed to be impaired in the workplace*

The above definition uses the term "workplace," and therefore that term should also be defined. "Workplace" is already defined in the Arizona Occupational Safety and Health Act, A.R.S. § 23-401(15), and therefore the same definition should be used in these regulations. It is as follows:

> *"Workplace" means any location or site wherein work, either temporary or permanent, is being conducted in connection with an industry, trade or business.*

Another term used in the Medical Marijuana Act, as well as in the above proposed definition of "monetary or licensing related benefit under federal law or regulations" that should be defined is "impaired." It is not defined in the proposed rule. The following is a recommended definition of "impaired:"

> *"Impaired" means displaying symptoms that an individual may be under the influence of drugs or alcohol that may reduce the employee's fulfillment of the duties or tasks of the employee's job position, including, but not limited to, symptoms of the employee's speech, walking, standing, physical dexterity, agility or coordination, actions,*

movement, demeanor, appearance, clothing, odor, or other symptoms causing a reasonable suspicion of the use of drugs or alcohol

The above definition of "monetary or licensing related benefit under federal law or regulations" includes the term "safety-sensitive positions," and the concept of safety-sensitive positions is also a part of the Department of Transportation regulations dealing with drug testing. Using the Department of Transportation regulations as a foundation, the following is a recommended definition of "safety-sensitive positions," which should be included in the Department's rules:

"Safety-sensitive positions" means positions in which an impaired employee could pose a risk to the safety of the employee or others, including but not limited to, pilots, school bus drivers, truck drivers, train engineers, mass transit operators, aircraft maintenance personnel, fire-armed security personnel, watercraft operators, pipeline workers, emergency response personnel, operators of motor vehicles, other vehicles, machinery, power tools, performing duties repairing, maintaining or monitoring the performance or operation of any equipment or machinery the malfunction of which could result in injury or property damage, or performing duties in the residential or commercial premises of a customer, supplier or vendor

3. The Rules Should Include Criteria for Evaluating Applications for Dispensary Registration Certificates.

The Arizona Chamber believes that it is in the interests of all affected parties, including employers, employees, the public, and users of medical marijuana, for the Medical Marijuana Act to be implemented with the most effective system possible for dispensing marijuana in a manner that complies with the law and regulations.

A lynchpin of a system to prevent abuse would be the selection of the most qualified applicants to be certified as dispensaries. The number of dispensaries is limited by statute to one dispensary for every 10 pharmacies operating in an area. A.R.S. § 36-2804(C). The proposed regulations, Section R9-17-107(G), contemplate that the Department shall issue certificates for qualified applicants; however, the proposed rules do not have any procedure for the Department to distinguish between multiple applications in the same area. The Department should therefore establish criteria to determine the most qualified applicants so that if the Department receives more than one application for every 10 pharmacies in an area, the Department should select the

most qualified applicant, as that will help promote compliance with the law and regulations thereafter.

In order to evaluate the most qualified applicants for dispensary certification, the Department should develop the criteria for evaluating and ranking the applicants. The Arizona Chamber believes that the most objective and fairest system would be to utilize a point system with criteria that emphasizes security over the inventory of the dispensaries, the qualifications and strength of the owners/operators of the dispensaries, and other factors. It is in the interests of all affected persons, as well as employers, to minimize the potential abuse through lack of inventory control and other procedures, and for that reason the Arizona Chamber supports objective selection criteria for determining the most qualified dispensary applicants who will be certified.

4. The Status of Entities Certified to be Dispensaries Should be Clarified.

The proposed rules contain ambiguity with respect to the status of the entities that are certified as medical marijuana dispensaries. The Act provides that the dispensary must be a "not-for-profit entity," but the Act does not contain a definition of or a requirement for the form of the entity that may be certified. Although the Act would seem to exclude individuals from operating a dispensary business as a proprietorship, it is unclear about the permissibility of partnerships or limited liability corporations. The rules contain various provisions that are applicable to officers and board members, which are positions commonly associated with corporations but not with partnerships, R9-17-301.

The rules should therefore clarify the status of the entities to be certified so that employers and others will not face any uncertainty with respect to whom is responsible for the actions of medical marijuana dispensaries. The rules should either expressly require that the certified entity be a corporation, which will assure that there will be officers and board members, or the rules should modify the definition of "principal officer or board member" to encompass persons such as the managing member of a LLC or the general partner of a partnership.

5. The Rules Should Allow for a Market-Based System for Allocation of Supplies Among Certified Dispensaries.

The Arizona Chamber generally supports market solutions to supply and demand issues, rather than government regulation of the private sector, as expressed in our guiding principles listed earlier. The free-market system on which on our economy is based contains inherent strengths to allocated and balance supply and demand.

The proposed rules contain a requirement that each dispensary must cultivate at least 70% of the supply distributed by the dispensary. That regulatory approach could result in inefficiencies and distribution issues. If some medical marijuana dispensaries have superior programs for maintaining inventory control and cultivation of supplies, the regulatory and framework should allow for those benefits from a market-based system to be achieved.

It could be in the interests of the state to have a fewer number of cultivation sites rather than requiring that each dispensary also cultivate 70% of its own supply. Dispersing and fragmenting the cultivation to each dispensary in greater quantities and to produce greater quantities of product could cause greater inventory control issues because it will cause a larger number of cultivation sites to exist than what otherwise might be the case in a free-market system. The greater number of and smaller size of cultivation sites could result in less inventory control and greater diversion of inventory outside the controlled system for potential misuse, and other problems.

Accordingly, we recommend that R9-17-307(C) be modified so that the mandates for cultivation and the restriction on acquiring supplies from other dispensaries are deleted.

6. Inventory Control Procedures Should be Strengthened to Include Department Monitoring Procedures and Electronic Tracking of Inventory.

Although the Arizona Chamber generally does not support government regulation of businesses, in the case of the inventory of medical marijuana dispensaries, it is important that there be rules that will assure the tracking of inventory by each dispensary from the cultivation through the distribution to the consumer, and compliance monitoring by the Department.

It is important for employers that the marijuana cultivated and distributed as a result of the Medical Marijuana Act be limited to those who are qualified under the Act, and that the supplies not be distributed among the general population which could cause marijuana use among non-qualifying employees to increase. In order to prevent the unauthorized distribution and use of marijuana, the Department's rules should require that each dispensary maintain inventory control and document the amount of marijuana cultivated, stored, and sold by each dispensary. Only through a comprehensive monitoring system from cultivation through distribution can there be assurances that product is not grown and redirected to the illegal market, or that inventory is not dissipated to the illegal market without being sold.

The inventory control system should allow for real time tracking through electronic data that can be verified remotely by the Department. The deterrent effect of the Department's ability to remotely verify the inventory control procedures will hopefully be effective, and therefore

avoid time-consuming paperwork audits that the Department undoubtedly lacks the resources to conduct.

Consequently, we recommend modifying R9-17-313 to require that each dispensary implement an electronic inventory control system that will also provide the Department with the ability to remotely access the cultivation data, inventory control and sales data for each dispensary.

7. Security Requirements for Storage of Medical Marijuana Inventories by Dispensaries Should be Strengthened.

As previously stated, maintaining the effectiveness of the inventory control systems to prevent supplies from being redirected from the medical marijuana distribution chain to the illegal drug market is important to the interests of employers and others. Part of those security precautions should include enhanced requirements to mandate that medical marijuana inventories should be stored only in secure locations and containers so that supplies are not redirected to the illegal market as a result of break-ins, thefts, dispensary employee misconduct, and other potential abuses. Those enhanced inventory storage control requirements should be added to R9-17-315.

8. Transportation Security Requirements Should be Added to the Rules.

Consistent with the desirability of enhanced security procedures for the storage of medical marijuana inventory, the rules should be strengthened to create security procedures for the transportation of medical marijuana, either in the form of plants while still being cultivated, or marijuana supplies after cultivation. Requirements that dispensaries maintain both electronic record-keeping to track transportation of product, as well as security procedures during transportation, should therefore be added to Section R9-17-315.

9. Biometric Identification Procedures for Recipients of Medical Marijuana Should be Added.

Employers have experience with the challenges and difficulty of verifying the identity of persons. The I-9 process imposed by the Immigration Reform and Control Act places upon employers the burden of checking documentation to verify the identify and employment eligibility of all newly-hired employees. The difficulties and lack of effectiveness of employers operating with a system that mandates acceptance of more than 20 different forms of identification have resulted in both expense, regulatory burden and controversy well-known to all Arizonans who have followed the immigration issue. Even the E-Verify system that is

voluntary on a federal basis, but mandated in Arizona, has been found by studies commissioned by the federal government to be ineffective and permit about one-half of those unauthorized to work to be successfully cleared by the system.

Consequently, any system of marijuana distribution that does not have effective verification procedures will run the risk of being thwarted by identity fraud that can enable supplies to be diverted to non-qualified recipients The Arizona Chamber supports a rule that would mandate a biometric identification system for each qualified recipient. Technology is available to have a fingerprint-based system or other comparatively effective system to verify the identity of the qualified users.

Accordingly, a rule should be added at R9-17-302 to require a fingerprint biometric system of verification of the identity of qualified recipients and caregivers before each distribution of medical marijuana as an alternative system that is similarly effective. R9-17-311 should be modified to require the verification of the patient or caregiver's identity through use of either a biometric fingerprint reading system or other equally effective biometric verification system

10. Conclusion

The Arizona Chamber of Commerce and Industry appreciates the opportunity to submit its views and recommendations regarding the proposed draft regulations to implement the Arizona Medical Marijuana Act. The Arizona Chamber remains ready, willing and able to assist the Department regarding the implementation of the Act and would welcome further opportunities to exchange views and explore these issues

Sincerely,

Glenn Hamer
President & CEO

AzPA
ARIZONA PHARMACY ALLIANCE

1845 E. Southern Avenue, Tempe, AZ 85282 (480) 838-3385

AzPA Medical Marijuana Position Statement

AzPA strongly opposes any law which bypasses the normal process of normal chains of custody for drug distribution which is through a pharmacy. Since the new AZ law defines marijuana for use for medical purposes, it should therefore be treated as a medication/drug. Therefore, AzPA recognizes the need for federal legislation to change/re-classify marijuana from a C-I to C-II and commits to raise this issue with national pharmacy organizations and AZ Congressional delegation in order to ensure safe delivery of all medications in Arizona. In addition, because marijuana is a drug classified as a controlled substance Class-I and is illegal and a violation of federal law to possess, AzPA strongly recommends that pharmacists do not get involved in the dispensing of the medical marijuana to avoid risk of losing their pharmacy license.

Recommendations:

1. AzPA recommends that the users of medical marijuana be identified in a database or that a dispensary report users through a database so that health care professionals can identify patient user for safe treatment. AzPA would support changing Arizona law so that C-I are required to be reported into the ASBP prescription monitoring program.
2. AzPA recommends that the state implement post marketing surveillance through the UofA Poison Control Center to track adverse drug events and monitor quality, safety and efficacy.
3. AzPA recommends only dispensaries that have policy and procedures and operates to ensure the delivery of quality medical marijuana and standardized dosing of medical marijuana be granted a dispensary license since pharmacies cannot be involved at this point in time.
4. AzPA does not support use of a drug which has severe health implications/adverse effects similar to smoking tobacco cigarettes.

Mr. Humble

Please keep the 70/30% growing rule in your rules package.

You already know that the big players from Colorado and California are lobbying you to remove the 70/30 % rule.

If you remove the 70/30 rule, we ask that you also remove the requirement that a dispensary applicant is required to list a grower on the application.

Otherwise, every person who applies for a dispensary permit, will have to be in bed with a grower from CO or CA to demonstrate experience for success.
These big growers are encouraging us to list them as our grower and sign contracts with them, because of their "experience."
Arizona has many experienced growers--patent-winning botanists and agricultural savants who have vast experience and are extremely capable.

The CO and CA growers want to be the sole growers to force dispensaries to buy from them. I don't blame them. We could still set up our own growing facility, but for application purposes would be forced to contract with them in order to have a complete application listing legal growers.
We've done the math. At current production and purchase rates, MM will cost 10x more which we'll have to then pass on to the patients.

Thank you for your thorough analysis.

[redacted]

R9-17-315. Security

A. A dispensary shall ensure that access to the enclosed, locked facility where marijuana is cultivated is limited to principal officers, board members, and designated agents of the dispensary.

B. A dispensary may transport marijuana in any form, marijuana plants, and marijuana paraphernalia between the dispensary and:

1. The dispensary's cultivation site,
2. A qualifying patient,
3. Another dispensary, and
4. A food establishment contracted with the dispensary to prepare edible food products infused with medical marijuana

C. During transportation,

1. All marijuana, marijuana plants, and marijuana paraphernalia shall be in a locked container or otherwise secured to minimize the potential of theft,
2. All marijuana, marijuana plants, and marijuana paraphernalia shall be under the immediate control of a Dispensary Agent at all times,
3. Dispensary Agents transporting shall possess a means of communications in the event of an emergency, and
4. Any loss, theft or compromise of marijuana, marijuana plants, and marijuana paraphernalia shall be reported to the appropriate law enforcement agency by a Dispensary Agent immediately upon discovery, and to the Department as soon as practicable

~~C~~**D.** To prevent unauthorized access to medical marijuana at the dispensary and, if applicable, the dispensary's cultivation site, the dispensary shall have the following:

1. Security equipment to deter and prevent unauthorized entrance into limited access areas that include:

a. Devices or a series of devices to promptly detect unauthorized intrusion, which may include a signal system interconnected with a radio frequency method, such as cellular, private radio signals, or other mechanical or electronic device;

b. Exterior lighting at a level sufficient to facilitate visual surveillance;

c. Electronic monitoring including:

i. At least one 19 inch or greater call-up monitor;

ii. A video printer capable of immediately producing a clear still photograph from any video camera image;

iii. Video cameras:

(1) Providing unobstructed coverage of all entrances to and exits from limited access areas and all entrances to and exits from the building, capable of identifying any activity occurring in or adjacent to the building; and

(2) Have a recording resolution of least at 704 x 480 or the equivalent;

iv. A video camera at each point of sale location allowing for the identification of ~~any~~ each qualifying patient or designated caregiver purchasing medical marijuana;

v. A video camera in each grow room capable of identifying all~~ny~~ activity occurring within the grow room in low light conditions;

vi. Electronic ~~S~~storage and retrieval capabilities of video recordings and still images from the video cameras for at least 30 calendar days;

vii. A failure notification system that provides an audible and visual notification of any failure in the electronic monitoring system;

viii. Video cameras and recording equipment with sufficient battery backup to support at least five minutes of recording in the event of a power outage; and

ix. The capability of providing authorized remote viewing of live and recorded video with:

(1) Internet connectivity of at least 384 kbps upstream; and

(2) A static IP address to allow for remote connection;

d. Panic buttons in the interior of each building; and

2. Policies and procedures:

a. That restrict access to the areas of the dispensary that contain marijuana and if applicable, the dispensary's cultivation site, to authorized individuals only;
b. That provide for the identification of authorized individuals;
c. That prevent loitering;
d. For conducting electronic monitoring; and
e. For the use of a panic button; and.
f. That are reviewed and updated at least annually or more often as needed.
E. A principal officer, board member, or designated agent of the dispensary shall ensure that any crime occurring on the premises of the dispensary is reported to the appropriate law enforcement agency immediately, and reported to the Department as soon as practicable.

Dear Mr Humble:

The City of Maricopa appreciates the diligence and efforts of your staff in writing of the draft rules for Proposition 203, and the opportunity to comment. The following observations are for review and your consideration:

General Comment

- Proposition 203 – Arizona Medical Marijuana Act does not address or provide clarification whether Sovereign Nations in the state are exempt from the rulemaking. Will DHS address this in their final rulemaking? The City of Maricopa is bordered by the Gila River Indian Community to the north and Ak-Chin Indian Community to the south, and information in this matter will help the City draft zoning regulations accordingly.

- It appears that DHS will require dispensaries, cultivation site location etc. to acquire zoning clearance prior to DHS issuing registration certificate/ license. Many municipalities are requiring the applicants' to provide some sort of evidence or approval from DHS prior to issuing of a certificate of occupancy. What happens if the applicants' fail to meet DHS requirements?

Informal Draft Rules Comment

1 R9-17-101 # 15 Medical Director AND
R9-17-302 # 15 (a) Registered Pharmacist; are they used interchangeably? If so, is there difference in role between the two, and will the pharmacist be required to be on site as well?

2 R9-17-302 # 15 (b) *The dispensary will provide information about the importance of physical activity and nutrition onsite*. Please clarify.

3. R9-17-313 # B (5) *For providing medical marijuana to food establishment for infusion into an edible food product.* The "food establishment" terminology as used here is too broad and will need clarification with an appropriate definition. Will restaurant fall under this terminology and required to meet zoning regulations?

4 R9-17-318 Physical Plant- is this definition same as dispensary and cultivation site?

5. The question of separation (distance from church, daycare rehabilitation center etc.), shouldn't this provision be subject to local regulation?

Once again, we are appreciative of this opportunity to comment and be part of the process

Sincerely,

Kazi Haque
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"The City of Maricopa will be open, responsive, and accountable while serving the public with integrity."

[redacted]

Questions / comments about Medical Marijuana Act & Rules
Physician licensing boards / directors comments

1 The term "recommend" (in any form) does not appear in the text of the actual statute (appears in initiative cover sheet and in preamble). It only appears in R9-17-310, as "recommending" physician. Other references use language "provided certification" such as in R9-17-108, and R9-17-202 (F)(5). May consider changing language in R9-17-310 to "certifying physician"

2. Regarding access to records:

a Regarding the boards' access to dispensary records/ medical records at dispensaries: most of physician boards have authority to subpoena records from any health care institution defined in 36-401 Is DHS considering amending that statute to include dispensaries? Is it DHS' position that the MM Act and rules already provide that authority? will we be able to get them, as do with Board of Pharmacy's Controlled Substances - Prescription Monitoring Program? Board access to DHS compiled records, also?

b. Who (besides DHS) will have access to the MM electronic verification system records? Will this be similar to the Controlled Substances Prescription Monitoring Program overseen by the Board of Pharmacy, in that individual health care providers may check on their patient, and licensing boards and law enforcement agencies will also have access for investigations?

3 Standards for writing certification for patient; (see R9-17-202 (5) (e) (ii) as an example)

a " primary responsibility" This term is not clear; are you requiring the certifying physician to become the patient's primary care provider? If so, using that readily recognized terminology would be helpful

The reality is, most patients are concurrently treated by a number of physicians, many of whom are specialists in the area of the debilitating condition/disease from which the patient is suffering While it would be the ideal scenario, for example, that a cancer patient receive a certifying statement from his/her oncologist, that may not occur, leading the patient to seek out another physician for that certifying statement. Does assuming "primary responsibility" require that the certifying physician take over the cancer therapy?

The boards would welcome language that encouraged communication between the certifying physician and other concurrent health care providers. For example, could an affirmative duty of certifying physician be added, that he/she send a copy of qualifying cert to other (currently/within past 6 months) treating health / mental health providers? Or, will other providers have access to the MM electronic system to see if patient getting MM / how much, etc? (this would be similar to how providers can now check other rxs via Pharmacy's CS- PMP).

b. "personal review of records . . other treating physicians" You may wish to broaden this to include all licensed health care providers with prescribing privileges, noting, for example, that patients may be under the care of advance practice nurses To keep this from being an onerous requirement, you may consider establishing a minimum time period, for example, review records of treatment / prescribing for past 12 months.

Does DHS see itself as the agency that will enforce this requirement? Or does DHS expect the physician licensing board to do so? If so, does DHS see itself forwarding cases to the boards for investigation?

Recommended DHS regulation on Arizona's Medical Marijuana Law

Proposed Change: Medical marijuana should not be dispensed in a form that can be smoked and it should remain illegal to smoke marijuana, even for someone with a registry card.

Suggested language: The following should be added to Arizona Department of Health regulation R9-17-311:

7. Marijuana may not be dispensed in its raw form or in any form that can easily be used by smoking it. Marijuana should only be dispensed in forms that can be taken orally, such as in foods or mixed with oil or butter and made into capsules, or rectally, as in suppositories. The dispensary will keep records listing the form in which the marijuana is dispensed. Marijuana for medical use cannot be transported in its raw form. It must be turned into a dispensable form within 100 feet of the place where it is grown.

All marijuana dispensaries must post a warning that can be easily seen by anyone purchasing medical marijuana. The warning states: "Marijuana smoke contains known carcinogens and has been determined to be carcinogenic by ADHS. Medical marijuana can only be dispensed in forms that are taken orally or rectally. Smoking marijuana obtained for medical use is considered illegal diversion and can be prosecuted. Possessing raw marijuana and smoking marijuana are still illegal under Arizona law."

Rationale: Marijuana smoke contains dozens of carcinogens, and preliminary research shows that smoking marijuana can increase the risk for respiratory

problems and several types of cancer–lung, head and neck, testicular and bladder. I review some of the research below. The medical profession and others in public health have made a huge effort for several decades to eliminate the smoking of tobacco because it's such a serious health hazard, and doctors should not recommend any substance to be smoked.

Following the adage, "First, do no harm," doctors should always prescribe medications by the least harmful route of administration. And, in fact, we always try to give medications orally. For people whose illness makes it hard to take a pill or to keep one down, we have skin patches and suppositories. The last resort is injecting medicine. But there is no precedent for a medication that is smoked. To my knowledge, there is no medicine prescribed today that is smoked, and for good reason. Smoking any plant material causes cancer and lung damage. And there is no need for a medication that is smoked; there is nothing that smoking accomplishes from a medical point of view that can't be accomplished by safer routes of administration. Arizona should forbid the dispensing of medical marijuana in any form that can be easily smoked.

As a doctor, I firmly believe that marijuana for medical use should never be dispensed in a form that can be smoked. Marijuana can be made into capsules or suppositories or cooked into food, and those are the only routes of administration that should be permitted.

Here's some of the research on problems caused by smoking:

Research has shown that marijuana smokers have several respiratory tract changes including lesions that are considered pre-cancerous. So far there is no

evidence of emphysema, but smoking marijuana does cause problems with airflow obstruction.

There are a small number of studies of cancer in marijuana smokers, some positive, some negative. Negative studies are quite common in research, and all they mean is this particular study did not find this particular result. Negative studies do not prove that something never happens unless the same research repeatedly gives negative outcomes and there are never positive outcomes. Remember, nobody bats 1000.

However, many pro-marijuana websites and media outlets have taken a single negative study and claimed marijuana does not cause cancer. There are also articles designed to look scientific that make this claim. This is an incorrect reading of the research.

Two studies did show no increase in cancer in marijuana users, but both studies have been criticized for bias. One large study (Tashkin 2006) of 1200 people with head, neck and lung cancer showed no increase in cancer in marijuana smokers. Tashkin was the same researcher who had previously found that marijuana caused pre-cancerous changes in the respiratory tract, so he was surprised to find no increased cancer risk. That large study has been criticized for selection bias—marijuana users in the control group were more likely to also smoke cigarette than the marijuana users in the group with cancer. The authors admitted selection bias possibly explained their negative findings.

One other study published in the American Journal of Public Health in 1997 (Sidney et al) that found marijuana smokers had no increase in cancer has been

criticized for using subjects who were too young, so cancers would not have had time to develop.

There are several research studies showing increased cancer rates in marijuana smokers.

A New Zealand study published in the European Respiratory Journal in 2008 looked at 79 patients with lung cancer and found the risk of lung cancer increased by 8 percent for every joint-year (averaging one joint daily for one year) and 7 percent for every pack-year (averaging one pack of cigarettes daily for one year), leading them to conclude that smoking marijuana posed the same lung cancer risk as smoking cigarettes.

Three North African case studies showed a very strong link between marijuana smoking and lung cancer, but none of these studies controlled for tobacco use, so these results are questionable.

A 2009 study done at the Fred Hutchinson Cancer Research Center in Seattle and published in the journal Cancer found that men who smoked marijuana once a week had twice the risk of testicular cancer when compared to men who never used marijuana, and marijuana was most strongly linked to nonseminoma, the most aggressive form of testicular cancer.

Research published in the journal Urology in 2006 showed increased rates of bladder cancer in marijuana smokers. They also found that marijuana-smoking patients were younger at the time of diagnosis than most patients with bladder cancer. Cigarette smoking is a major risk factor for bladder cancer, but the

researchers concluded that smoking marijuana may be as bad or worse than cigarette smoking as a risk factor for bladder cancer.

In 1999, a study published in the journal Cancer Epidemiology found that squamous cell carcinoma of the head and neck increased with marijuana use and there was a strong dose-response curve, the heavier marijuana users had higher rates of cancer. However, in 2004, another study published in Cancer Research found no association between marijuana use and squamous cell carcinoma.

This is not a complete list of studies, and there aren't many. So it is not enough to draw definitive conclusions on marijuana and cancer. However, the evidence that smoking marijuana is linked to cancer is far more substantial than the research supporting marijuana as treatment for many of the disorders listed in Arizona's new medical marijuana law. Also, remember, it took decades of heavy tobacco use by large swaths of the population before we had a definitive link between tobacco smoking and cancer.

On several pro-marijuana websites I found the claim that there is no direct evidence linking marijuana smoking to lung cancer in humans. That is exactly what the tobacco industry said for decades after the first studies came out linking cigarette smoking with lung cancer. What they said was technically true; until recently we did not know for certain the exact mechanism by which smoking caused cancer. However, the statistical evidence was overwhelming, so the tobacco industry was being completely disingenuous and so are the pro-marijuana groups who say marijuana doesn't cause cancer. Anyone who claims that marijuana does not cause cancer is ignoring the research.

Also, in November 2010 an article printed in the European Journal of Immunology described a possible mechanism by which smoking marijuana causes cancer and the research supporting this possible mechanism. If further studies support these findings, then we will have direct evidence linking marijuana smoking to cancer in humans.

Anyone who goes on the internet will find the pro-marijuana groups misrepresenting research. What they almost always do is take one study or one bit of information and run with it as if that were the whole story. That's how Arizona ended up with a law that says marijuana is good for glaucoma even though the Glaucoma Foundation warns patients not to use marijuana because it could make their symptoms worse.

The American Cancer Society points out on its website that it's hard to study marijuana and cancer because so many marijuana users also smoke cigarettes and because it's hard to study illegal drugs. British cancer researchers noted the same problem.

However, one part of the research is very clear. We know for certain that marijuana smoke contains many of the same carcinogens as tobacco smoke, produces more tar than tobacco, and that the way people smoke marijuana (down to the roach, unfiltered, inhaling deeply, holding it in) delivers more tar to the lungs than the way people smoke tobacco.

California's Office of Environmental Health Hazard Assessment ruled in 2009 that marijuana smoke is carcinogenic. They are not calling the marijuana plant a carcinogen, just the smoke. That seems right; the research shows a link between

smoking marijuana and several types of cancer also commonly caused by smoking tobacco. There is no evidence that ingesting marijuana by other methods causes cancer.

Smoking marijuana is also linked to respiratory problems. Research shows that marijuana smokers have decreased respiratory function, increased airflow obstruction, and fewer of the anti-oxidants that protect against cancer and heart disease.

In summary, smoking marijuana has been implicated in several health problems including cancer. Not definitively, but enough evidence to make it likely. So no doctor should be recommending marijuana in a form that can be smoked. Arizona should not allow such a potentially dangerous route of administration.

Marijuana can be mixed into food, formed into a suppository, or cooked in vegetable oil or butter and put into a capsule. Dispensaries should only be allowed to dispense marijuana in these forms, and they should not be allowed to sell marijuana in a form that can be smoked.

Marijuana users have responded to the harm of smoking by developing vaporizers so they can continue to inhale cannabinoids without the dangers of smoking. However, the reason for vaporizing marijuana is still to get a quick high, just like smoking it. It still offers no medical advantage over taking cannabis orally or rectally, and it allows marijuana to be dispensed in the same form that can be smoked, allowing diversion. Besides, the vaporized product has not, to my knowledge, been tested for carcinogens.

I suggest a rule against transporting marijuana in its raw form, and a requirement that marijuana be turned into dispensable forms where it is grown. This will help to distinguish recreational from medicinal use. It will also help law enforcement because, in other states with medical marijuana laws, it is a common practice for drug dealers to get marijuana cards so they can claim the marijuana they are carrying around is for medical use.

Most of all, though, I ask DHS please do not force doctors to recommend carcinogens just because they decide to recommend marijuana to their patients. And marijuana smoke is full of carcinogens.

The marijuana users who sponsored this law in the hope of surreptitiously legalizing recreational marijuana will come up with all sorts of reasons that marijuana should be dispensed in its raw, easily-smoked form. I know how convincing the stories of some of my substance abusing patients can be, but please do not believe them. And if you do find yourselves believing them, then at least let's try for one year with a rule that marijuana cannot be dispensed in it's raw form or any form that can be easily smoked. And after a year we can assess the situation and see if anyone with genuine medical need was really harmed by such a regulation.

I quote a lot of research in the above discussion. You can find links to all the research at my website, http://edgogek.com.

Ed Gogek, M.D. Prescott, Arizona 928 443-0032

Recommendations to ADHS relative to the Medical Marijuana Act.

1. To eliminate unscrupulous doctors abandoning legitimate practices in lieu of specializing in providing marijuana cards or becoming full-time out-of-control "Pot Docs" as experienced in other medical marijuana states; The following mandate should be included:

   Suggested language

"All doctors listed under the Medical Marijuana Act who are authorized to recommend medical marijuana are limited to a maximum of 'thirty' medical marijuana recommendations per year."

Also, the following language should be stricken entirely from the rules:

" OR (a physician who) -Has assumed primary responsibility for providing management and routine care of the qualifying patient's debilitating medical condition after conducting a comprehensive medical history and physical examination, including a personal review of the qualifying patient's medical record maintained by other treating physicians that may include the qualifying patient's reaction and response to conventional medical therapies:

2. Currently the rules do not require an examination to be "in-person". Out-of-state on-line services are already attempting to pre-qualify potential Arizona medical marijuana cardholders on-line by requesting the forwarding of medical records and filling out medical questionnaires. To prevent on-line examinations or on-line doctor-patient relationships; the following requirement should be included as part of a legitimate examination establishing a true in-person doctor–patient relationship.

   Suggested language:

"A 'valid recommendation' for medical marijuana requires in-person medical evaluation of the patient."

"It is unlawful to 'recommend' medical marijuana solely based on a patient's completion of an online medical questionnaire."

3. ADHS needs to create a closed system of medical marijuana sales tracking between growers, caregivers, dispensaries and cardholders. This are systems currently utilized by many legitimate retail pharmacies to track the sale of pseudoephedrine products to ensure sales to the ultimate-user do not exceed legal amounts and prevents the "smurffing" of pharmacies due to a compatible data-base allowing pharmacies to share information. This system will also ensure that marijuana is not being obtained from illegal sources.

   Suggested language:

"ADHS will require all licensed growers, marijuana dispensaries and caregivers to install and /or subscribe to a secure, computerized web-based tracking system determined by the ADHS. The real-time logging and reporting of regulated medical marijuana product sales, electronic signature capture, and secure storage of all transaction data will be required for all purchases of medical marijuana.

All medical marijuana growers, dispensaries and caregivers must be equipped with a shared electronic purchasing database determined by the ADHS. This system will be shared among growers, dispensaries, caregivers and the ADHS. When a licensed grower sells product to a dispensary or caregiver, it will generate an ID reference number; the grower's license number, date and time of sale; name of dispensary or caregiver, and the purchaser's name and address; name of product sold, quantity and amount of marijuana in the product; and purchaser's signature.

At the time a licensed dispensary or caregiver sells product to a cardholder, it will generate an ID reference number; the cardholder number, date and time of sale; purchaser's name and address; name of product sold, quantity and amount of marijuana in the product; and purchaser's signature.

Entering the cardholder's information will fill required ID information into the system. The information instantly checks a centralized database to determine if the cardholder is within the

legal purchase limit. The cardholder will confirm the sale with an electronic signature, and the sales transaction information is sent and stored to the centralized database.

Non-compliance of the web-based tracking system will result in an immediate revocation of grower, dispensary, caregiver, and cardholder licensing, or permits and; may be subject to criminal prosecution, civil fines and forfeiture.

It is unlawful for a grower, dispensary, caregiver, or cardholder, to knowingly consume, possess, acquire, purchase, or transport marijuana of an unknown source or origin; other than from ADHS licensed growing facilities, dispensaries or caregivers. Non-compliance will result in an immediate revocation of dispensary, caregiver, and cardholder licensing, or permits; and will be subject to criminal prosecution, civil fines and forfeiture."

4. The disposal of medical marijuana (unused or expired) is referenced in the inspection rules – but there is no mention as to what approved method of destruction is authorized by ADHS. To prevent diversion, it is imperative that ADHS provide strict guidelines relating to the destruction of unused or expired marijuana. The discarding of medical marijuana in local dumpster landfill etc. is unacceptable.

"Medical marijuana dispensaries, caregivers, and cardholders can dispose of unused or expired marijuana by documenting the weight and taking it to a local law enforcement agency for secure storage and destruction."

5. Indoor grows often involve the utilization of various fungicides, pesticides, fertilizers, acids, bases and soil. Many homes are contaminated with mold and chemical exposure as a result of improper storage and disposal of the aforementioned chemicals rendering the home a toxic waste-dump. In addition, there are oftentimes children living in these homes who are exposed to these toxic chemicals.

   Many states allowing indoor marijuana grows are plagued with an increase in residential fires endangering the lives and neighborhoods. This is due to amateurs altering residential electrical and plumping fixtures to accommodate indoor grow lighting and watering.

"Residential or commercial cultivation (authorized by ADHS) within the jurisdiction of a municipality or county will require a special use or conditional use permit authorizing the marijuana grow.

Cultivation of medical marijuana inside a residence or property occupied by minor children is prohibited.

Rental properties used as a cultivation site are the sole responsibility of the medical marijuana dispensary owner, caregiver and/or cardholder residing in the residence.

Planned alterations to rental property by the tenants must be approved by the landlord. Clean-up costs associated with an indoor grow to restore a property to its original state will be the sole responsibility of the medical marijuana dispensary/owner, caregiver or cardholder renting the property.

Alterations to fixed residential electrical systems, plumbing, or other permanent structural features will require applying for the appropriate permit through the local municipality or county. Construction must be completed by a licensed contractor. Once alterations are complete, the local city or county (ie: Inspector, Fire Dept.) shall inspect the residence to ensure all alterations are constructed to code.

Illegal grows are subject to criminal prosecution in addition to civil fines and possible forfeiture."

Proposed Regulation: Requirements for Physicians Who Recommend Medical Marijuana

Submitted by Ed Gogek, M.D. Prescott, AZ 928 443-0032

I notice there is no section or article about requirements for the doctors who recommend medical marijuana, with the one exception of the documentation they provide to the patient. As a doctor, I would normally like that--a law that does not give us extra paperwork or administrative responsibilities. However, certain requirements are necessary to make sure doctors cannot abuse their authority to write medical marijuana recommendations. In particular, doctors should not be able to set up practices where they making a living handing out marijuana cards to everyone who walks through their door, which has been a huge problem in other states.

Limiting doctors to only 30 active marijuana patients at a time would prevent the type of pot doctors other states have, doctors who just hand out marijuana recommendations all day long to anyone who can pay their fee. The 30-patient limit would not be a problem for legitimate doctors, because they only recommend marijuana to patients who need it. Marijuana is not a first line medication for any medical condition or disorder, so legitimate doctors will not recommend it often.

The precedent for this is the exact same rule used for doctors who prescribe buprenorphine when used to treat drug addicts. In order to use buprenorphine in my practice, I had to take an 8 hour course and then got a certificate from the DEA. Even so, the law limits me to 30 active buprenorphine patients at a time. When one patient finishes his or her course of buprenorphine, I can add another. However, I never go as high as 30 because I'm very strict about who gets it. If I handed out buprenorphine to everyone who requested it, I'd reach my 30 patient limit in a few weeks, maybe even sooner once the word got out among the drug-abusing community.

The DHS guidelines should also include some system for authorizing doctors to recommend medical marijuana. It should be very simple so it won't be a problem for the doctor who only recommends it occasionally. This would be exactly like the requirement that doctors get a DEA certificate before prescribing scheduled medications like benzodiazepines, narcotics and stimulants.

Lastly, physicians who do recommend medical marijuana should be able to revoke a patient's card for a number of reasons. This is the case with all other prescription medications and should be the case with medical marijuana as well. Especially with addictive drugs and drugs of abuse, doctors often find it necessary to cancel a prescription, cancel refills or stop giving a patient a medicine they had previously prescribed.

So, I suggest the following additions to the proposed DHS regulations:

First, I suggest the following definition be added to R9-17-101, Definitions:

> *"Recommending doctor" or "recommending physician" is the physician writing a recommendation for medical marijuana.*

Second, I suggest that R9-17-205 include one more subsection, under the letter "I":

> *I. The recommending physician may contact the Department to revoke a qualifying patient's registry identification card if the doctor believes the patient no longer requires medical marijuana, if the patient fails to follow up with the doctor as prescribed, if the doctor comes to believe that the patient was dishonest in obtaining the recommendation, if the doctor believes the patient is using the marijuana for recreational purposes or diverting it to others who are using it for recreational purposes, or if the doctor believes the patient is misusing the marijuana recommendation in any other way. The recommending physician is also required to contact the Department to revoke a qualifying patient's registry identification card if the patient has not seen the doctor for more than 90 days. If a recommending doctor contacts the Department for any of these reasons, the Department will revoke the patient's registry identification card.*

Thirdly, I recommend an additional article, which would be Article 4:

Article 4. Recommending Physicians

Definition: A recommending physician is a physician writing the marijuana recommendation that the patient uses to obtain a registry card.

1. All physicians must register with DHS in order to recommend the medical use of marijuana.

(This should be a simple process, otherwise it discourages doctors who might only recommend the drug a few times. Doctors should be able to call a number at DHS and then receive a letter or fax saying they are registered. DHS should require the doctor's name, degree, office address, phone and fax numbers, and any specialties or subspecialties, even if they are not board-certified in the specialty. When a doctor receives a registry with DHS as a recommending physician, it should be accompanied by a description of what is required of the doctor, so they know the law. All this can be done by fax or phone in a matter of 15 minutes.)

2. All physicians recommending medical marijuana must keep a record of patients receiving the recommendation. The record must include the name, birthdate, diagnosis, reason for marijuana recommendation, date marijuana first recommended, dates the patient has been seen since the first recommendation, and date the recommendation was terminated.

(This is similar to the requirements for buprenorphine. DHS should look at what is required for buprenorphine and devise a simple form for doctors to use and keep as part of their office record. This is not an onerous requirement as all the information is already in the patient's medical record. Please don't require us to copy this out of the medical record and keep it anywhere else, just let us know it must be in the medical record. Then the only extra thing doctors will be required to do is to keep a list of patients currently using marijuana medically, and when they were last seen, which are needed for Parts 3 & 4. This is exactly what I do for patients on buprenorphine.)

3. Patients receiving marijuana recommendations for medical use must be seen by the recommending physician at least every 90 days to continue the recommendation. Otherwise, the

recommending physician is required to contact the Department to request that the patient's registry card be revoked. Recommending doctors may also contact the Department to ask that a patient's registry card be revoked, as deemed medically appropriate, as set out in R9-17-205-I.

(I made suggestions above to be included in R9-17-205 as to when a doctor can have a card revoked, so if those are included, then they can be referred to here.)

(This section is similar to the rule with stimulants which are Schedule II drugs. Prescriptions for stimulants, used for ADHD, are only good for 60 days, so usually the patient must be seen every two months. Some doctors simply write prescriptions every two months and just let the patients pick them up, but ADHD is not a debilitating medical condition. Anyone with a genuinely debilitating medical condition will be seeing their doctor at least every 3 months anyway, and it will not pose a hardship.)

4. No doctor may have more than 30 patients receiving medical marijuana at any one time. The recommending doctor and the Department are required to maintain ongoing records of the number of patients with active registry cards for each recommending physician.

(This is identical to the rule the DEA has for buprenorphine. Thirty should be plenty for all legitimate doctors. The only people this rule will pose a hardship for are doctors who want to earn a living handing out marijuana recommendations, and those are the people we want to stop. This is the most important recommendation in this list. In fact, from my point of view as a doctor, the 30-patient limit and the requirement that marijuana only be transported and dispensed in forms that cannot be smoked, are the two most important suggestions I have to make. If you just do those two things, along with the recommendation made by others that dispensary permits be awarded geographically so no square inch of the state is more than 25 miles from a dispensary, then this law will be transformed from a recreational marijuana law into a medical marijuana law, which is what the voters intended.)

5. Second opinions will be required for certain marijuana recommendations as part of the application for a registry card. DHS will keep a list of acceptable doctors for second opinions. DHS will ask each specialty group to recommend doctors of high moral and ethical character in each community, city, or town. DHS will choose doctors from this list for its second opinion list. Patients required to get a second opinion must see a specialist in the diagnosis for which they have been recommended marijuana. Pain specialists are not acceptable for second opinions. If the patient has cachexia, wasting syndrome, severe and chronic pain, severe nausea, or muscle spasms, those are considered symptoms, and the patient must see a specialist in the underlying disease that causes the symptom.

(For example, if they have musculoskeletal pain they must see an orthopedist or specialist in osteopathic manipulation, not a pain specialist.)

(Second opinions are used in medicine to prevent inappropriate prescriptions. They are most commonly used when surgery is prescribed, and the use of second opinions has prevented a lot of unnecessary and inappropriate surgery. However, the state of New Mexico uses second opinions as part of its medical marijuana law for certain diagnoses. Second opinions are useful in medical marijuana laws when the disorder has only subjective symptoms and is easily faked, like pain.)

6. Second opinions are required for: a) any patient under the age of 18, b) any patient recommended marijuana for pain or muscle spasms, c) any patients recommended marijuana for nausea, cachexia or wasting syndrome not caused by cancer, HIV or interferon treatment for hepatitis C, d) patients with muscle spasms not part of multiple sclerosis, and e) any patient who receives a marijuana recommendation at their first or second visit to an individual doctor, clinic or medical group. The only exceptions to part e are patients diagnosed with cancer by radiologic or cytologic evidence and receiving cancer chemotherapy who receive a marijuana recommendation from an oncologist at their first or second visit.

(Section e will not be necessary if DHS includes teh much stronger already-suggested requirement that patients must

be treated by the recommending doctor for at least one year with at least 4 prior physician visits.)

7. Physicians providing a second opinion are not required to make their decision on the day they evaluate the patient. They must be given time to obtain and evaluate records from other physicians and other ancillary sources. If they decide the patient does not need marijuana, then the patient will not be given a registry identification card.

8. DHs may revoke or suspend a physicians registration to recommend medical marijuana as the director's discretion, and then the physician is not permitted to recommend marijuana unless the registration is reinstated at the director's discretion.

[redacted]

To DHS Staff

As you contemplate the development of regulations for implementation of Proposition 203 We strongly recommend that you include the recommendations put forward by Ed Gogek, M D namely that :

1. Marijuana dispensaries only dispense marijuana in food, in capsules or as suppositories, but never in its raw form or in any other form that can be smoked. Marijuana smoke contains dozens of carcinogens and research links pot-smoking to several types of cancer and respiratory problems. An extensive description of the research can be found at my website, http://edgogek.com.

2. Doctors who recommend medical marijuana can have a limited number medical marijuana patients at a time. This is the same as the rule for buprenorphine. The reason for this rule is that, in other states, almost all the marijuana is recommended by a handful of doctors who set up marijuana practices and earn their living handing our recommendations to anyone who pays their fee. A 30-patient limit will stop these pot doctors

Thank you for consideration of our concerns

Sincerely,

Gene A. Gerber, DDS, MPH

Linda Ott

Scottsdale, Arizona

YAVAPAI COUNTY SUBSTANCE ABUSE COALITION - *MATFORCE* COMMENTS ON INITIAL DRAFT RULES ARIZONA MEDICAL MARIJUANA INITIATIVE

January 7, 2011

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3. Caregivers, Cardholders and Dispensary Agents must be residents of Arizona and must possess a Arizona driver's license or identification card.

4 Caregivers must be subject to the same security, inspection and reporting requirements as dispensaries.

5. Patients, or caregivers acting on behalf of patients, may not possess smokeable marijuana unless specifically authorized by DHS

6. Private marijuana use "clubs" should be prohibited.

7. The Rules and statute should clearly state that the use of medical marijuana by Visiting Qualifying Patients should be limited to only those conditions and circumstances allowed to Patients under Arizona law.

V. MEDICAL PROFESSIONALS

1 Policy Statement.

2. Medical professionals that wish to issue medical marijuana certificates must be registered with DHS in order to issue certifications and a reasonable fee should be charged.

3. The medical professional issuing the certification should be given the authority to revoke a patient's certification at any time. In addition, the medical professional should be required to revoke if they haven't seen the patient within 6 months.

VI. LEGISLATIVE ACTION

23 1. The legislature should set a presumptive THC metabolite level for impairment (similar to presumptive blood alcohol level) effective in situations of driving, machinery operation and employment.

24 2. The legislature should set enhanced penalties for cardholders, caregivers, and dispensary agents that produce, transport, sell, or possess marijuana outside of the terms of their authority granted by the initiative.

25 3. The legislature should impose criminal penalties for smoking marijuana in public.

26 4. The legislature should impose criminal penalties for smoking marijuana in the presence of children.

II. GUIDING POLICIES

1. Cultivation, sale, transportation, possession and use of marijuana are criminal offenses in the state of Arizona. Medical marijuana is a narrow exception to that policy.

It is the policy of the State of Arizona that marijuana production, possession, use, sale or transportation are all felony offenses. Through the initiative process the people of Arizona have carved out a narrow exception to the criminalization of marijuana. The initiative allows those individuals that have a bona-fide medical need for marijuana use to acquire, possess, and use marijuana to treat symptoms associated with a narrow range of medical conditions. However, the guiding policy of this state – and the federal government – is that it remains a crime to produce, use, sell or transport marijuana in Arizona

In other states such as California and Colorado, insufficient regulation and enforcement has allowed the "exception" of medical marijuana to swallow the "rule" of marijuana criminalization. This must not be allowed to happen in Arizona. In order to enforce Arizona's strong policy of marijuana criminalization, policies and procedures developed by DHS and the legislature under the medical use exception should, to the greatest extent possible, control marijuana production, transportation, sale, possession and use to insure that marijuana is allowed for medical purposes only. Medical marijuana should not be allowed to become a source of illicit marijuana; production should be limited to only what is necessary to supply legitimate demand and should be strictly tracked; medical need should be based on medical facts subject to objective review; employers should not be forced to tolerate impaired employees or protect employees that are in violation of federal law

To these ends we suggest the following:

II. DISPENSARIES

1. DHS must require geographic dispersion of dispensaries.

Rationale:

The initiative allows individuals and caregivers to produce their own marijuana if they live more than 25 miles from a licensed dispensary (the 25 mile circle surrounding a dispensary have been called "halos.") Individual production of marijuana is far more difficult to monitor and control than production by dispensaries. This marijuana can easily be converted to illicit use and the production location will attract criminal activity as well. Lawful marijuana production for medical purposes by individuals should be eliminated to the greatest extent possible.

DHS should adopt policies that mandate dispensary locations that cover the state in dispensary "halos" that have the effect of preventing individual marijuana production. DHS should have the ability to consider in its sole discretion whether or not the geographic location of a proposed dispensary is appropriate. DHS regulations should allow DHS to award exclusive dispensary rights to geographic areas. DHS regulations should allow DHS to mandate that an applicant, as a condition of granting a dispensary certificate, also apply for and obtain a dispensary certificate at another location in the state designated by DHS. In short, DHS policies must insure that most if not all of the state is covered with dispensary "halos" so that no individual will be permitted to produce their own marijuana. This may be best accomplished by requiring dispensaries in urban areas to operate dispensaries in rural locations as a condition of their dispensary licenses.

Implementation:

Substitute for R9-17-107(F) as follows:

"The Department may in its sole discretion consider the geographic location of the proposed dispensary in determining whether to grant a certificate. In its sole discretion, the Department may grant exclusive dispensary certification to any geographic area of the State. The Department may as a condition of granting a certificate pursuant to A.R.S. Title 36 Chapter 28.1 and this Chapter, require the applicant for dispensary registration to apply for, obtain, and maintain another dispensary within the state of Arizona within 2 miles from a location designated by the Department."

DISPENSARIES, CONT.

2. Each location where marijuana is produced, infused or sold must have a separate dispensary certification.

Rationale:

The Rules as currently written would double and possibly triple the number of dispensaries within the state. The Rules as written allow a dispensary to both have a separate location for cultivation and a separate location for infusion.

A.R.S. §36-2801 defines "Nonprofit medical marijuana dispensary" as an entity that acquires, possesses, cultivates, manufactures, delivers, transports supplies, sells or dispenses marijuana . . .". A.R.S. §36-2804(C) limits the number of dispensary certificates to approximately 124. A.R.S. §36-2806(C) requires each certified nonprofit marijuana dispensary to have a single secure entrance.

If the holder of a single dispensary certificate is allowed to have multiple locations for sale or cultivation, or to contract with others to infuse food, it would be physically impossible for the dispensary certificate holder to comply with A.R.S. §36-2806(C). Thus, when these sections are read together, it is clear the intent of the initiative is to require each physical location where marijuana is produced, infused or sold have a separate dispensary certificate that counts toward the total allowed in the state under A.R.S. §36-2804(C). This rationale also comports with the overall goal of maintaining tight control over medical marijuana use so it cannot be diverted to illicit use.

Implementation:

(a) Modify R9-17-302(B)(5) by striking "and, if applicable, as the dispensary's cultivation site."
(b) Modify R9-17-304 to strike all references to a Dispensary's Cultivation Site.
(c) Modify R9-17-306 to strike all references to a dispensary's cultivation site
(d) Modify R9-17-307 to clarify that cultivation sites require separate dispensary certification.
(e) Modify R9-17-313(B)(5) and (6) to clarify that food infusion sites require separate dispensary certification
(f) Modify R9-17-315 to clarify that cultivation and infusion sites require separate dispensary certification
(g) Modify R9-17-316 to clarify that infusion sites require separate dispensary certification.
(h) Strike R9-17-101(6)

DISPENSARIES, CONT.

3. DHS may delegate inspection of dispensaries to local authorities.

Rationale:

Pursuant to A.R.S. §36-136, DHS may delegate to local authorities their power to regulate matters of health and welfare in the state. Nothing in the initiative forbids delegation of inspection authority to local governments. The ability to delegate this authority will allow DHS to better effectuate control of dispensaries, and will give local authorities the ability to better control the health and safety impacts of dispensaries in their communities.

Implementation:

Add R9-17-306(H): "The Department may delegate its authority under this section to local authority pursuant to A.R.S. §36-136."

DISPENSARIES, CONT.

4. Reasonable notice of routine inspections should be 24 hours, and occur within posted business hours.

Rationale:

Inspection of dispensaries is designed to insure that the dispensary is operating within the limits of the law. The rule as currently written gives the dispensary the option of refusing a time suggested by DHS. The initiative requires only that the inspection be reasonable. Given the strong policy of this state against marijuana possession or use, it is imperative that DHS inspections provide an accurate picture of the dispensary's operation. 24 hour notice of an inspection to occur during posted business hours fulfills the statewide policy against illicit marijuana use and fulfills the "reasonable notice" provision of the initiative

Implementation:

Modify R9-17-306(C) as follows:

"Except as provided in subsection (E), routine on-site inspection of a dispensary shall occur no earlier than 24 hours after the Department submits written notice of the Department's intent to inspect the dispensary. Routine inspections under this subsection shall occur during the dispensary's normal business hours"

DISPENSARIES, CONT.

5. Dispensaries must dispense marijuana and marijuana infused products in DHS approved and supplied containers.

Rationale:

In order to strictly control medical marijuana, it is important that DHS and law enforcement be able to clearly and easily distinguish between marijuana possessed, sold, or transported pursuant to the initiative. The containers must be distinctive and traceable with bar codes or other computerized tracking system. Distinctive containers that are registered or supplied by DHS that can be easily identified will help DHS and law enforcement insure that marijuana encountered is in fact produced pursuant to the initiative and is used strictly for medical use. The containers should be sealed when dispensed. DHS should strongly consider developing standardized containers and requiring dispensaries to obtain those containers from DHS.

Implementation:

Add to R9-17-314(A)(7): "The marijuana shall be dispensed in a sealed container approved by the Department. The containers shall contain a bar code or other computerized tracking system approved by the Department."

DISPENSARIES, CONT.

6. Dispensaries may not dispense a smokeable form of marijuana unless the qualifying patient is approved by DHS to receive it.

Rationale:

Based on the proven health risk of smoking, for the past 45 years the medical community has worked to curtail the use of smoking in the United States. In November, 2006 Arizona voters passed the Smoke-Free Arizona Act (A.R.S. §36-601.01), severely curtailing the use of smoking in the state. For most people, marijuana's alleged therapeutic benefits are effective when it is consumed orally. Given the serious negative health effects that come with smoking any product (including marijuana), the smoking of marijuana should be strongly discouraged.

Implementation:

Modify R9-17-311 to require the dispensary verify the patient is authorized to receive marijuana in a smokable form prior to dispensing.

Include the requirement that all smokeable marijuana must be dispensed in a container that prominently displays a warning in substantially the following form: "Marijuana smoke contains known carcinogens and has been determined to be carcinogenic by the Arizona Department of Health Services. Although preliminary research shows marijuana may contain substances that may help in the treatment of cancer, this research also shows that smoking marijuana may be linked to cancer of the lung, skin of the head and neck, testicle and bladder."

DISPENSARIES, CONT.

7. Dispensaries should be required to file public reports providing information on the number of customers, marijuana sales volume, and financial status of the dispensary.

Rationale:

In order to insure that dispensaries are not operating illicitly, it is important that the legislature, DHS, local authorities, and the public have information regarding a dispensary's number of customers, volume of marijuana, and financial condition. A dispensary need not reveal specific information about individual customers in order to publish public reports regarding the number of customers, the volume of marijuana dispensed, the kind of marijuana dispensed (smokeable or infused food), the receipts of sales and costs expended. This information will allow the legislature, DHS, local law enforcement and the public to insure that the dispensary is not in reality a "front" for criminal activity, and that the marijuana produced and dispensed only to those with legitimate medical need

Implementation:

Add as R9-17-312(E):

"Not less than annually and prior to recertification under R9-17-305, a dispensary shall submit to the Department a report covering the period from the last certificate was issued to that dispensary that contains the following information: (1) the total number of sales of marijuana products, detailing each kind of product sold; (2) the total amount of usable marijuana sold; (3) the total amount of usable marijuana produced or otherwise procured; (4) the total amount of marijuana on hand; (5) the total amount of cash or other reimbursement realized for the sale of marijuana; (6) the total amount of cash or other reimbursements paid for producing or acquiring marijuana."

III. PATIENTS, CAREGIVERS AND DISPENSARY AGENTS

1. Caregivers must pay a separate fee for each patient they care for.

Rationale:

Caregivers may possess and assist in the use of marijuana for up to 5 qualifying patients under the act. Each patient that designates a caregiver requires additional administrative scrutiny by DHS, increasing administrative costs. A.R.S. §36-2803(A)(5)(a) requires that the total revenue from the fees for registry identification cards and dispensary registration certificates must be sufficient to implement and administer the program. Given the additional administrative costs inherent in a caregiver assisting multiple patients, and to insure that caregiver activity is adequately monitored, it is reasonable that a caregiver be required to pay additional fees for additional patients

Implementation:

Modify R9-17-102(5)(b) and (6)(b) as follows: "Designated Caregiver, $200 per patient for which caregiving services are provided."

PATIENTS, CAREGIVERS AND DISPENSARY AGENTS, CONT.

2. Caregivers must undergo training (at least 8 hours) on, and pass a test on, the effect and hazards of marijuana, the terms of the initiative, and DHS rules governing medical marijuana.

Rationale:

Caregivers under the initiative administer marijuana to qualifying patients. They are the link between the patient and the dispensary, and need to know the effects and alternatives to marijuana to properly administer medical marijuana. Without adequate training, the caregiver runs the risk of improperly procuring or administering marijuana to the patient

Implementation:

(a) Add R9-17-202(F)(6)(l): "Certification of completion of a Caregiver Training Class administered or approved by the Department."

(b) Add R9-17-206: "The Department shall develop a Caregiver Training Class of no less than 8 hours to teach caregiver applicants about the effects and hazards of marijuana, alternatives to marijuana use, the terms of the Arizona Medical Marijuana Initiative, and these rules. The class shall include a test designed to reasonably test caregivers about the subjects taught in the class. Before issuing a certificate of completion to caregiver applicants, the applicant shall pass the test with a score of at least 80%."

PATIENTS, CAREGIVERS AND DISPENSARY AGENTS, CONT.

3. Caregivers, Cardholders and Dispensary Agents must be residents of Arizona and must possess an Arizona driver's license or identification card.

Rationale:

The initiative declares that its purpose is to remove state-level criminal penalties for medical marijuana use for the citizens of Arizona. Other states such as California and Colorado have allowed non-citizens to participate in medical marijuana programs, which resulted in a tremendous increase of illicit use of marijuana due to cross-border smuggling of marijuana. The use or administration of marijuana under the initiative should be narrowly tailored for the use and benefit of Arizona citizens that are in need of medical marijuana. Patients, Caregivers, and Dispensing Agents should be required to prove they are citizens of the State of Arizona by producing identification cards issued only to Arizona citizens – an Arizona Driver's License, or an Arizona Identification Card.

The current draft of rules allows a patient or caregiver to obtain a registry card by showing a U.S. passport as proof of identity. A U.S. passport contains no information about the person's state of residency. In addition, because of the potential for criminal activity inherent in a person's possession of marijuana, registry with the Department of Public Safety's driver's license/identification card system will allow law enforcement to obtain additional information about a caregiver/patient that is involved with criminal activity.

Implementation:

(a) Strike R9-17-105(F)
(b) Strike R9-17-107(F)(1)(d)(iv)
(c) Strike R9-17-202(F)(2)(d)
(d) Strike R9-17-202(F)(6)(i)(iv)
(e) Strike R9-17-202(G)(6)(d)
(f) Strike R9-17-203(A)(2)(i)(c)
(g) Strike R9-17-204(A)(5)(f)(iv)
(h) Strike R9-17-308(5)(d)

PATIENTS, CAREGIVERS AND DISPENSARY AGENTS, CONT.

4. Caregivers must be subject to the same security, inspection and reporting requirements as dispensaries.

Rationale:

Caregivers are operating small dispensaries. They acquire marijuana in the same fashion as dispensaries, and distribute the marijuana to others. They are subject to the same security risks as dispensaries, and have the same potential for diverting marijuana to illicit activities as dispensaries.

Implementation:

Apply appropriate provisions of Article 3 (R9-17-301 to R9-17-320) to caregivers allowed to cultivate marijuana for patients.

PATIENTS, CAREGIVERS AND DISPENSARY AGENTS, CONT.

5. ***Patients, or caregivers acting on behalf of patients, may not possess smokeable marijuana unless specifically authorized by DHS.***

Rationale:

Based on the proven health risk of smoking, for the past 45 years the medical community has worked to curtail the use of smoking in the United States. In November, 2006 Arizona voters passed the Smoke-Free Arizona Act (A.R.S. §36-601.01), severely curtailing smoking in the state. For most people, marijuana's alleged therapeutic benefits are effective when it is consumed orally. Given the serious negative health effects that come with smoking any product (including marijuana), the smoking of marijuana should be strongly discouraged.

Implementation:

(a) Add to R9-17-202(F)(5) the following: "If the physician is recommending the patient be dispensed a smokeable form of marijuana, then a statement detailing the at least 3 efforts of the physician and patient to administer infused marijuana, a statement detailing why such attempts were unsuccessful, and a declaration from the physician why only smokeable marijuana will alleviate the patient's condition."

(b) Add to R9-17-202(G)(13) the following: "If the physician is recommending the patient be dispensed a smokeable form of marijuana, then a statement detailing the at least 3 efforts of the physician and patient to administer infused marijuana, a statement detailing why such attempts were unsuccessful, and a declaration from the physician why only smokeable marijuana will alleviate the patient's condition."

(c) Add to R9-17-204(B)(4)(f) and R9-17-204(B)(4)(g) the following: "If the physician is recommending the patient be dispensed a smokeable form of marijuana, then a statement detailing the at least 3 efforts of the physician and patient to administer infused marijuana, a statement detailing why such attempts were unsuccessful, and a declaration from the physician why only smokeable marijuana will alleviate the patient's condition."

(c) Issue patient and caregiver cards that clearly indicate if the patient is allowed to possess smokeable marijuana.

(d) Indicate in the Department data base available to dispensaries and law enforcement whether the patient or caregiver is allowed to possess smokeable marijuana.

PATIENTS, CAREGIVERS AND DISPENSARY AGENTS, CONT.

6. Private marijuana use "clubs" should be prohibited.

Rationale:

As written, Rule R9-17-101(18) (a) would exclude private clubs from the definition of public place. This would allow marijuana users to form private "smoking" clubs where marijuana users could gather and use marijuana. The goal of the initiative is to provide medical marijuana that qualifying patients and their caregivers may administer for medical purposes, not to establish private marijuana use clubs. Private "smoking clubs" create opportunities to divert medical marijuana to illicit use, and pose a safety and security threat to the communities in which they are located.

Implementation:

Modify R9-17-101(18)(a) to read as follows: "[Public place:] Means any location, facility, or venue that is not intended for the regular exclusive use of an individual or the non-commercial use of a specific group of not more than 5 individuals."

PATIENTS, CAREGIVERS AND DISPENSARY AGENTS, CONT.

7. The Rules and statute should clearly state that the use of medical marijuana by Visiting Qualifying Patients should be limited to only those conditions and circumstances allowed to Patients under Arizona law.

Rationale:

With the exception of obtaining marijuana from a dispensary, A.R.S. §36-2804.03(C) limits the rights of a Visiting Qualifying Patient to the rights of a registration card holder in Arizona. Thus this section limits the medical conditions that qualify a Visiting Qualifying Patient for the protections of the initiative to those conditions that qualify an Arizona patient for a registration card. The Visiting Qualifying Patient should be required by statute to provide proof that they medically qualify for a registration card under Arizona law.

A Visiting Qualifying Patient's is also limited to cultivation of marijuana by those that are residents of Arizona for less than 30 days and that reside outside of the 25 mile dispensary limit, and only for the 30 day limit. A Visiting Qualifying Patients that does not reside in Arizona is not allowed to cultivate marijuana, because they do not have a residence in the state (see Patients, Caregivers and Dispensary Agents #3, above) Statutory changes should make this clear.

Implementation:

DHS should propose legislation that requires a Visiting Qualifying Patient to prove they have a Debilitating Medical Condition as defined by A.R.S. §36-2801(3) before they are given the same protection as a registry card issued by DHS. The legislation should also clarify that cultivation of marijuana by a Visiting Qualifying Patient is a criminal offense.

IV. MEDICAL PROFESSIONALS

1. Policy Statement

Three different types of medical professionals are authorized to provide certification for medical marijuana use under the initiative. All are governed by a different licensing board, and none of the licensing boards actively govern their respective charges with regard to medical marijuana. Unless DHS monitors the activities of these medical professionals, there is no central authority to monitor and govern the actions of medical professionals authorized to certify medical marijuana use under the initiative.

Under the initiative, DHS is charged with regulating possession and use of medical marijuana. DHS thus has the authority to qualify medical professionals designated under the act as appropriate to issue certification for medical marijuana use. Such a system would ensure a centralized authority to monitor medical professionals for abusive or illicit issuance of certifications, preventing fraud and abuse.

MEDICAL PROFESSIONALS, CONT.

2. Medical professionals that wish to issue medical marijuana certificates must be registered with DHS in order to issue certifications and a reasonable fee should be charged.

Rationale:

Registration with DHS would allow the Department to determine the qualifications of medical professionals that wish to certify medical marijuana use. DHS can examine proof of the medical professional's certification as a medical doctor, osteopath, or naturopath, and of their primary practice in Arizona. DHS can determine if the medical professional is currently undergoing discipline or substance abuse counseling. DHS can determine the number of patients the medical professional has certified for marijuana use, and can monitor the number and quality of contacts between the patient and the medical professional. DHS can monitor the number and justification for certifications of smokeable medical marijuana use.

Implementation:

Create Article 4 for the Medical Marijuana Program in DHS Rules that governs medical professionals wishing to issue medical marijuana certifications in Arizona. Medical professionals must meet the following requirements:

(a) DHS must create and administer a medical professional certification registry

(b) Qualified medical professionals that wish to issue certificates under the initiative must register annual with DHS and pay a reasonable annual fee to offset the cost of registry administration.

(a) Medical professionals must be Arizona licensed in and primarily practice in Arizona.

(b) No more than 30 active patient registry cards may be issued based on the certification of an individual medical professional at any one time.

(c) Medical professionals must see their certified patient at least once every 6 months, face to face, and document they have done so in annual certifications.

(d) Medical professionals may not issue certificates to themselves or immediate family

(e) Medical professionals undergoing discipline or substance abuse problems must not be authorized to certifications.

(f) Medical professionals recommending the patient be dispensed a smokeable form of marijuana, must provide a statement detailing the at least 3 efforts of the medical professional and patient to administer infused marijuana, a statement detailing why such attempts were unsuccessful, and a declaration from the medical professional why only smokeable marijuana will alleviate the patient's condition.

MEDICAL PROFESSIONALS, CONT.

3. ***The medical professional issuing the certification should be given the authority to revoke a patient's certification at any time. In addition, the medical professional should be required to revoke if they haven't seen the patient within 6 months.***

Rationale:

Medical marijuana is the narrow exception to the criminalization of marijuana in Arizona. In addition to rules requiring previous and ongoing relationship between a certifying medical professional and a patient, the medical professional must be able to de-certify a patient if they believe the patient no longer qualifies for medical marijuana. In addition, the medical professional must de-certify the patient if they have not seen the patient within 6 months.

Once de-certified, the patient must be presumed to no longer qualify for medical marijuana unless re-certified by two different medical professionals that are aware of the previous de-certification. This would insure that patients are seeing their medical professionals on a regular basis, and insure that medical marijuana is continued to be needed by the patient. It would also encourage medical professionals to act ethically in certifying, and prevent "doctor shopping." If certification is revoked, the patient must present certifications from two other medical professionals, both of whom state they are aware of the patient's certification revocation, before a new registry card may be issued.

Implementation:

(a) Add to new Article 4 a requirement that the medical professional must notify the Department within 3 business days if the patient no longer qualifies for certification for medical marijuana, or if the medical professional has not had a face to face contact with the patient for more than 180 days.

(b) Add R9-17-205(I) to require the Department to revoke a Qualifying Patient's Registry Identification Card upon notification by the certifying medical professional that the patient no longer qualifies for certification or that the medical professional has not had a face to face contact with the patient for more than 180 days.

(c) Add to R9-17-202, 203, and 204 a section that requires certification from two medical professionals for any person applying for a registry identification card after having had a previous one revoked under R9-17-205(I), and require both certifications state that the medical professional is aware of the grounds for prior de-certification.

V. LEGISLATIVE ACTION

1. The legislature should set a presumptive THC metabolite level for impairment (similar to presumptive blood alcohol level) effective in situations of driving, machinery operation and employment

Rationale:

The initiative authorizes the use of marijuana for medical purposes, but does not allow a user to be impaired while employed or operating automobiles or other machinery. Use of marijuana impairs a person's ability to operate automobiles and other machinery, and to properly perform their job. Impairment is difficult to determine without presumptive standards. Marijuana impairment can be compared to use of alcohol, which is legal but impairment is not allowed when a person is operating automobiles or other machinery or by most employers. Levels of presumptive alcohol impairment are codified in law so employers and law enforcement may more easily determine if a person is impaired.

Scientific tests are available to determine the level of Tetrahydrocannabinol (THC) the active ingredient in marijuana, and standards exist that prove a person is impaired at blood levels of THC of 2.0 nanograms per milliliter (ng/ml) or greater. Presumptive levels of marijuana impairment for both employment and operation of automobiles and other machinery must be adopted by the legislature in order to allow employers and law enforcement to quickly and easily determine if probable cause exists that a person is impaired, and to take appropriate action to protect the person, the employer, and the public.

Implementation:

DHS must propose legislation that sets a presumptive level of marijuana impairment at a concentration of 2.0 ng/ml of blood THC for purposes of operating automobiles or other machinery, and for purposes of employment.

LEGISLATIVE ACTION, CONT.

2. The legislature should set enhanced penalties for cardholders, caregivers, and dispensary agents that produce, transport, sell, or possess marijuana outside of the terms of their authority granted by the initiative.

Rationale:

Arizona has a strong public policy against marijuana. The initiative has carved out a narrow exception to that policy for medical use. To uphold Arizona's prohibition against marijuana, it is imperative that those individuals granted access to marijuana through the initiative be strongly discouraged from using their access to marijuana to add to the supply of illicit marijuana in the state, or to supply it to those without authorization to possess marijuana. One of the best ways this may be accomplished is for the legislature to specify and clarify what constitutes illegal marijuana activity by dispensaries, cardholders and caregivers, and to enhance the punishments for those offenses. Such legislation will discourage dispensaries, cardholders and caregivers from using their access to marijuana for illicit purposes. Offenses should include cultivation without permission, transfer of marijuana to those not entitled to possession, consuming, transporting, selling, cultivating marijuana without the appropriate registry card in immediate possession.

Implementation:

DHS, working with state and law enforcement officials, should draft and propose legislation that provides specific and enhanced criminal penalties for dispensaries, cardholders and caregivers using or transferring marijuana in ways unauthorized by the initiative or regulation.

LEGISLATIVE ACTION, CONT.

3. The legislature should impose criminal penalties for smoking marijuana in public.

Rationale:

The initiative forbids smoking marijuana in public, but provides no penalty. Smoking of marijuana in public encourages its illicit use, and exposes marijuana to children. Since marijuana use in public is not authorized by the initiative and is a criminal activity in Arizona, smoking of marijuana in public by a cardholder should be made a serious criminal act

Implementation:

DHS, working with state and law enforcement officials, should draft and propose legislation that provides specific and enhanced criminal penalties for cardholders smoking marijuana in public

LEGISLATIVE ACTION, CONT.

4. The legislature should impose criminal penalties for smoking marijuana in the presence of children.

Rationale:

Children exposed to marijuana use are desensitized to the hazards of marijuana use, and are more likely to use marijuana illegally in the future. Children exposed to marijuana smoke will suffer the same health hazards as exposure to tobacco smoke. Smoking marijuana in the presence of children should be made a serious criminal act

Implementation:

DHS, working with state and law enforcement officials, should draft and propose legislation that provides specific and enhanced criminal penalties for cardholders smoking marijuana in the presence of those under the age of 18.